Rec'd from PCS 5/3/71

(Supersedes SF 89)

STANDARD FORM 93
JANUARY 1971
GSA FPMR 101-11.8

Approved
Office of Management and Budget No. 29-R0191

# REPORT OF MEDICAL HISTORY

**(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)**

| 1. LAST NAME—FIRST NAME—MIDDLE NAME | | 2. SOCIAL SECURITY OR IDENTIFICATION NO. |
|---|---|---|
| 3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)* | | 4. POSITION *(City, grade, component)* |
| 5. PURPOSE OF EXAMINATION | 6. DATE OF EXAMINATION | 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)* |

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

9. HAVE YOU EVER *(Please check each item)*

| YES | NO | *(Check each item)* |
|---|---|---|
| | | Lived with anyone who had tuberculosis |
| | | Coughed up blood |
| | | Bled excessively after injury or tooth extraction |
| | | Attempted suicide |
| | | Been a sleepwalker |

10. DO YOU *(Please check each item)*

| YES | NO | *(Check each item)* |
|---|---|---|
| | | Wear glasses or contact lenses |
| | | Have vision in both eyes |
| | | Wear a hearing aid |
| | | Stutter or stammer habitually |
| | | Wear a brace or back support |

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

| YES | NO | DON'T KNOW | *(Check each item)* | YES | NO | DON'T KNOW | *(Check each item)* | YES | NO | DON'T KNOW | *(Check each item)* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Scarlet fever, erysipelas | | | | Cramps in your legs | | | | "Trick" or locked knee |
| | | | Rheumatic fever | | | | Frequent indigestion | | | | Foot trouble |
| | | | Swollen or painful joints | | | | Stomach, liver, or intestinal trouble | | | | Neuritis |
| | | | Frequent or severe headache | | | | Gall bladder trouble or gallstones | | | | Paralysis (include infantile) |
| | | | Dizziness or fainting spells | | | | Jaundice or hepatitis | | | | Epilepsy or fits |
| | | | Eye trouble | | | | Adverse reaction to serum, drug, | | | | Car, train, sea or air sickness |
| | | | Ear, nose, or throat trouble | | | | or medicine | | | | Frequent trouble sleeping |
| | | | Hearing loss | | | | Broken bones | | | | Depression or excessive worry |
| | | | Chronic or frequent colds | | | | Tumor, growth, cyst, cancer | | | | Loss of memory or amnesia |
| | | | Severe tooth or gum trouble | | | | Rupture/hernia | | | | Nervous trouble of any sort |
| | | | Sinusitis | | | | Piles or rectal disease | | | | Periods of unconsciousness |
| | | | Hay Fever | | | | Frequent or painful urination | | | | |
| | | | Head injury | | | | Bed wetting since age 12 | | | | |
| | | | Skin diseases | | | | Kidney stone or blood in urine | | | | |
| | | | Thyroid trouble | | | | Sugar or albumin in urine | | | | |
| | | | Tuberculosis | | | | VD—Syphilis, gonorrhea, etc. | | | | |
| | | | Asthma | | | | Recent gain or loss of weight | | | | |
| | | | Shortness of breath | | | | Arthritis, Rheumatism, or Bursitis | | | | |
| | | | Pain or pressure in chest | | | | Bone, joint or other deformity | | | | |
| | | | Chronic cough | | | | Lameness | | | | |
| | | | Palpitation or pounding heart | | | | Loss of finger or toe | 12. FEMALES ONLY: HAVE YOU EVER | | | |
| | | | Heart trouble | | | | Painful or "trick" shoulder or elbow | | | | Been treated for a female disorder |
| | | | High or low blood pressure | | | | Recurrent back pain | | | | Had a change in menstrual pattern |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU *(Check one)*

☐ Right handed ☐ Left handed

93-101

| YES | NO | CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT | |
|---|---|---|---|
| | | 15. Have you been refused employment or been unable to hold a job or stay in school because of:<br>A. Sensitivity to chemicals, dust, sunlight, etc. | |
| | | B. Inability to perform certain motions. | |
| | | C. Inability to assume certain positions. | |
| | | D. Other medical reasons *(If yes, give reasons.)* | |
| | | 16. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details).* | |
| | | 17. Have you ever been denied life insurance? *(If yes, state reason and give details.)* | |
| | | 18. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occurred.)* | |
| | | 19. Have you ever been a patient in any type of hospitals? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)* | |
| | | 20. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)* | |
| | | 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)* | |
| | | 22. Have you ever been rejected for military service because of physical, mental, or other reasons? *(If yes, give date and reason for rejection.)* | |
| | | 23. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)* | |
| | | 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)* | |

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

| TYPED OR PRINTED NAME OF EXAMINEE | SIGNATURE |
|---|---|
| | |

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

| TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER | DATE | SIGNATURE | NUMBER OF ATTACHED SHEETS |
|---|---|---|---|
| | | | |



☆ GPO : 1971 O - 419-271